

Statement of Other Benefit Coverage for Dependent Child between ages 19 and 26

Subscriber Name: _____

Subscriber SSN: _____

Dependent Child Name: _____

Dependent Child Date of Birth: _____

Dependent Child SSN: _____

I recognize that the above mentioned dependent child is eligible for group health insurance coverage under my policy if that dependent child is not eligible for insurance benefits with his/her employer.

_____ Dependent child named above is not employed.

_____ Dependent child named above is not eligible for insurance benefits with his/her employer.

I attest that the information I have provided on this form is complete and accurate.

Signature

Date